Privacy Release Form
Office of Congressman Tim Walz

The Privacy Act of 1974 requires written consent from the constituent before information can be obtained from a government agency's records. To better serve you, please complete this form and return it to Congressman Walz's Rochester Office. <u>If you are inquiring on behalf of someone, that person must sign this form.</u>

☐ Mr.   ☐ Mrs.   ☐ Ms.   ☐   Dr.

Full Name   _____

Address   _____

City _____   **ZIP Code** _____

Social Security Number   _____   **Date of Birth** _____

Home Phone _____   **Work Phone** _____   **Cell Phone** _____

Email Address _____

I prefer to be contacted by:

☐ Home Phone   ☐ Work Phone   ☐ Cell Phone   ☐ Email

Federal agencies involved: _____

Have you contacted other Senate or Congressional offices about this issue? ☐Yes ☐No
If yes, who have you contacted?

Senator Coleman   Senator Klobuchar   Representative_____

I designate the following person(s) to discuss this matter on my behalf with Congressman Tim Walz and his staff (if applicable): _____

I freely and willing authorize Congressman Tim Walz and his staff to make inquiries into my personal records and or files to obtain information about me pertaining to my request for assistance. I understand that I may revoke this authorization at any time.

Signature   _____   **Date** _____

Please sign this form and send it to Congressman Walz at
1134 7th St. NW Rochester, MN 55901 or Fax: 507-206-0650

Please complete <u>all</u> sections that apply to your case

Please briefly explain your problem. In writing, provide a detailed account. Include any additional relevant correspondence that you have initiated or received concerning this matter.

Please state how you would like Congressman Walz to help you.

If your request for assistance involves medical information, please fill out the Authorization to Release Medical Information and return it along with this form.

<u>**Military or Veteran's Issues**</u>

Rank _____
Unit _____
Duty Station _____

<u>**Medicare Issues**</u>
I am having problems with:

Medicare Number _____   ☐ Part A ☐ Part B   ☐ Part D

Social Security Issues

Type of Claim Filed: _____

Has the claim been denied? ☐ Yes ☐ No
Office you are working with _____

Immigration Issues

Receipt Number _____
Name of Beneficiary _____

Alien Number A-_____
Date of Birth _____
Place of Birth _____

Type of Petition _____
Consulate Involved _____

Current Immigration Status_____